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Health Disparities in the Transgender Community: Exploring Differences in Insurance Coverage

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Health insurance is considered by many to be a basic human right. This study explored the differences in health insurance coverage and access to health care by comparing the results of data from 2 large datasets that were collected in 2008. Data from the National Health Interview Survey were compared with data from the National Transgender Discrimination Study. Results indicated that transgender and gender nonconforming (TGNC) individuals were less likely than cisgender (nontransgender) individuals to have health insurance ($\chi^2 = 13.3$). Further, TGNC individuals were less likely to have a primary care physician than cisgender individuals ($\chi^2 = 23.2$). The results of this study are indicative of the magnitude of health care disparities for TGNC individuals in the United States. Implications for practice and policy are provided.

Keywords: transgender, health disparities, insurance

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Health care is considered by many to be a basic human right. Although the Affordable Care Act holds promise for increasing access to health care for many U.S. citizens, transgender and gender nonconforming (TGNC) individuals continue to face barriers to accessing health care. TGNC people identify with a different gender than their sex assigned at birth (American Psychological Association, 2011) or have a gender expression that is different from what is typically associated with their sex assigned at birth (Institute of Medicine, 2011). TGNC individuals may experience barriers to accessing health care for numerous reasons, ranging from availability of TGNC-competent services to experiences of prejudice and discrimination. Although many TGNC individuals choose not to undergo gender-affirmative medical treatments, such as hormone therapy or surgery, those who do constitute a subpopulation with specific health needs that may not be met by the current health care system. The aim of the current study was to examine health insurance coverage and access to health care among TGNC and cisgender adults in the United States.

TGNC Health and Minority Stress

The growing body of research on transgender health suggests that TGNC individuals are at risk for numerous adverse mental and physical health outcomes (Institute of Medicine, 2011) pertaining to general health (e.g., preventative care) and transgender-specific health concerns (e.g., gender-affirming medical treatments such as hormones and surgery). Research has demonstrated that TGNC individuals report higher rates of mental health concerns compared with the general U.S. population (Budge, Adelson, & Howard, 2013; Clements-Nolle, Marx, & Katz, 2006; Grant et al., 2011) and compared specifically to cisgender men who have sex with men (Bockting, Huang, Ding, Robinson, & Rosser, 2005). Negative health outcomes specific to gender affirmative medical treatments may include potential side effects of hormone treatment, such as the increased risk of ovarian cancer among TGNC men who take testosterone (Hage, Dekker, Karim, Verheijen, & Bloemena, 2000; Pache et al., 1991).

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Health disparities between TGNC and cisgender individuals represent larger societal and cultural inequalities. Heterosexism, the system that stigmatizes nonheterosexuality (Herek, 1994) and its gendered counterpart cisgenderism, which stigmatizes any non-cisgender form of behavior, identity, relationship, or community (Ansara, 2010; Serano, 2007), both contribute to stigma of TGNC individuals, which may have negative effects on health. Experiencing prejudice and discrimination related to having a stigmatized identity, such as being TGNC, can produce negative health outcomes indirectly through minority stress (Hendricks & Testa, 2012; Meyer, 2003).

Prejudice and discrimination experienced specifically in the context of the health care system can produce negative health outcomes directly, in terms of inappropriate care or interventions (Meyer, 2001) or refusal of care. Grant et al. (2011) found that 19% of TGNC respondents experienced refusal of medical care, with even higher rates among racial/ethnic minorities. Experiences of minority stress in health care settings can also take the form of more subtle microaggressions, defined as commonplace verbal, behavioral, or environmental indignities, whether intentional or unintentional, which communicate hostile, derogatory, or negative slights and insults toward individuals from marginalized groups (Nadal, 2013; Sue, 2010; Sue et al., 2007). Microaggressions specific to TGNC individuals may include using the wrong pronoun or not using an individual's chosen name (Nadal, Rivera, & Corpus, 2010). Such experiences can result in delays in seeking health care in an effort to prevent repeated experiences of prejudice and discrimination (Grant et al., 2011).

Gender identity intersects with other marginalized identities, such as sexual identity, racial/ethnic minority, and low socioeconomic status (SES), to produce health disparities and barriers to accessing health care. A recent study found that TGNC individuals who report additional marginalized identities, including racial/ethnic minorities and individuals with a lower SES, report higher anxiety compared with TGNC individuals without these identities (Budge, Thai, Tebbe, & Howard, in press). TGNC individuals with additional intersecting marginalized identities may face substantial barriers to accessing health care.

Health Care Access and Barriers to Care

One of the most direct factors responsible for producing health disparities is access to health care, defined as the "timely use of personal health services to achieve the best possible outcomes" (Institute of Medicine, 1993, p. 4). Many minority and multiple-minority groups face barriers to accessing health care, largely due to a lack of health insurance. In 2008, when data for the current study were collected, approximately 15% of individuals in the United States were uninsured, with higher rates among racial/ethnic minorities and those with a lower household income (DeNavas-Walt, Proctor, & Smith, 2009). Grant et al. (2011) found that 19% of TGNC respondents were uninsured, with higher rates among African Americans and those living in southern regions of the United States.

Barriers to accessing health care exist at three levels: (a) institutional/structural barriers, (b) provider-level barriers, and (c) patient-level barriers (Hernandez & Fultz, 2006). Institutional/structural barriers affecting TGNC individuals' access to health care include a lack of insurance coverage of gender affirming medical treatments (Gorton, 2007), stringent treatment guidelines (Hale, 2007; Lev, 2009), and inattention to coverage of TGNC health needs in medical education programs (Obedin-Maliver et al., 2011). TGNC individuals, particularly those who are also racial/ethnic minorities, have a high level of poverty (Grant et al., 2011; Xavier, Bobbin, Singer, & Budd, 2005), which affects the ability to pay out of pocket for costly gender affirming medical treatments that are not covered by insurance. Previous versions of treatment guidelines for the TGNC population have been criticized for having a level of stringency that represented a serious barrier to care for TGNC individuals (Hale, 2007; Lev, 2009). Although newer versions of the guidelines (Coleman et al., 2012) are less stringent, many insurance companies are not yet following these guidelines. Finally, medical education programs are lacking in coverage of TGNC-specific health needs. The American Association of Medical Colleges (2014) recently released a curricular resource to improve competency among health care providers regarding medical treatment of sexual and gender minority individuals; however, the effectiveness of this program remains to be seen.

Provider-level barriers to care include a provider's ability to provide appropriate care for TGNC patients (Snelgrove, Jasudavisius, Rowe, Head, & Bauer, 2012). This is dependent in part on receiving culturally competent medical training and the elimination of health care provider prejudice and discrimination, which can affect the ability to care for TGNC patients. A qualitative study of HIV-related care found that health care providers felt discomfort when working with TGNC patients and lacked understanding of the complexities of TGNC-specific care (Lurie, 2005). Reports from sexual and gender minorities regarding experiences of inappropriate care related to prejudice and discrimination have been well documented, including refusal of treatment, verbal abuse, and disrespectful behavior (Budge, Katz-Wise, et al., 2013; Davis & Adams, 2001; Eliason & Schope, 2001; Grant et al., 2011; Kenagy, 2005; Scherzer, 2000). Health care providers who enact microaggressions toward TGNC patients may also create hostile health care settings, thereby reducing the chance that a TGNC person will seek care when needed.

Patient-level barriers to care for TGNC individuals include postponement of care based on previous experiences of prejudice and discrimination and lack of disclosure to health care providers. Patients who have previously experienced prejudice and discrimination in health care settings may be reluctant to seek health care or to disclose personal information, such as TGNC status, to health care providers if health care is sought (Grant et al., 2011; Willging, Salvador, & Kano, 2006). Other factors such as geographic location and social support may also affect health care access. The TGNC population is widely distributed across the United States, in both rural and urban locations (Rosser, Oakes, Bockting, & Miner, 2007). A TGNC individual living in a rural environment may have less access to health centers or health care providers who are knowledgeable about TGNC health than TGNC people who live in urban settings. Health is also linked to social networks, such as having friends or family to help with transportation to doctor's appointments or picking up prescriptions for medication. Many TGNC individuals have experienced rejection from family and friends

(Grant et al., 2011), which may affect their ability to obtain health care when help from others is needed.

The Current Study

Although recognition of disparities in health and health care access among TGNC individuals is increasing, more research is needed. The aim of the current study was to examine health insurance coverage and access to health care for TGNC adults as compared with a sample of cisgender adults. We hypothesized that TGNC individuals would be less likely to have insurance coverage and a primary care provider and more likely to access care through an emergency facility than cisgender individuals. We also examined differences in health care access and use based on sociodemographic factors, such as gender, race/ethnicity, and geographic region. To address the study aims, we performed a secondary analysis of data from the National Transgender Discrimination Study (NTDS) and the National Health Information Survey (NHIS).

Method

Participants

The NTDS was conducted for the primary purpose of understanding the ways in which TGNC individuals face discrimination (Grant et al., 2011). A total of 6,450 people responded to the initial NTDS survey in 2008. The current analytic sample included 6,432 people. Participants were excluded if they were missing data on key variables of interest (insurance coverage and place to receive medical care). Participants' gender for this sample included male-to-female (MTF), female-to-male (FTM), and part-time TGNC people. Part-time individuals were those who presented as male or female part of the time and female or male (respectively) the other part of the time. Individuals who reported living part-time in one gender should not be confused with individuals who have a genderqueer identity (i.e., those who do not subscribe to the gender binary and live on a gender spectrum). The question used to identify gender from the NTDS study did not include genderqueer as a gender choice. The average age for the full sample was 36.7 years (SD = 13.1), with a range of 18 to 89 years. Table 1 shows a breakdown of other demographic data for the sample. In 2015, the National Center for Transgender Equality launched a follow-up study to the 2008 NTDS. The authors are aware of this data collection. It took 3 years for the 2008 data to become available to researchers; therefore, these data are the most recent that are available for exploring the topic of health disparities in the TGNC community.

The NHIS is conducted annually by the Centers for Disease Control and Prevention (CDC) and the U.S. Census Bureau. Data collected in the survey have been used to "provid[e] data to track health status, health care access, and progress toward achieving national health objectives" (CDC, 2016). A total of 79,357 adults participated in the NHIS in the year 2008. A total of 21,780 participants from the NHIS were used for this study. This subset of the full NHIS data set includes only those people who reported their gender. The average age for participants was 47.9 years (SD = 18.0), with a range of 18 to 85 years. See Table 1 for a breakdown of other demographic information for the NHIS sample.

Table 1
Demographic Characteristics of the Samples

Variable	TGNC (NTDS) (n = 6,432)[1] n (%)	Cisgender (NHIS) (n = 21,780) n (%)
Gender		
Male	1,859 (28.9)	9,514 (43.7)
Female	2,712 (42.2)	12,266 (56.3)
Part-time	1,861 (28.9)	—
Age		
18–40	3,728 (63.4)	8,478 (38.9)
41–64	2,020 (34.5)	8,859 (40.7)
65 +	114 (1.9)	4,443 (20.4)
Race/Ethnicity		
White	4,856 (76.0)	13,288 (61.0)
Hispanic	305 (4.8)	3,522 (16.2)
Black/African American	295 (4.6)	3,365 (15.4)
Asian/Pacific Islander	160 (2.5)	1,277 (5.9)
American Indian	256 (4.0)	240 (1.1)
Other	30 (0.5)	35 (0.2)
Multiracial	485 (7.6)	53 (0.2)
Income		
$0 to 35,000	3,127 (50.1)	8,464 (41.9)
$35,000 to 50,000	537 (8.6)	3,091 (15.4)
$50,000 to 75,000	1,229 (19.7)	3,392 (16.8)
$75,000 to 100,000	485 (7.8)	2,065 (10.3)
More than $100,000	858 (13.8)	3,117 (15.5)
Education		
<High school diploma	261 (4.1)	3,749 (17.3)
High school diploma	539 (8.4)	5,853 (27.1)
Some college	1,765 (27.6)	4,308 (19.9)
AA/Technical Degree	814 (12.7)	2,091 (9.7)
Bachelor's	1,739 (27.2)	3,757 (17.4)
Master's	854 (13.4)	1,370 (6.3)
Professional/doctoral	421 (6.6)	503 (2.3)
Housing		
Own	2,074 (32.4)	13,432 (61.7)
Rent	2,711 (42.4)	7,702 (35.4)
Other arrangements	1,246 (19.5)	540 (2.5)
Campus	225 (3.5)	65 (0.3)
Shelter/homeless	145 (2.3)	10 (0.0)
Other	0 (0.0)	30 (0.1)
Region		
Northeast	1,458 (23.5)	3,561 (16.3)
Midwest	1,292 (20.8)	4,924 (22.6)
South	1,514 (24.4)	8,033
West	1,941 (31.3)	5,262

Note. TGNC = transgender and gender nonconforming; NTDS = National Transgender Discrimination Study; NHIS = National Health Information Survey.

For the purposes of this study, the NTDS sample included TGNC individuals only, and the NHIS sample included cisgender individuals only. It is possible that TGNC individuals are represented in the NHIS data; however, the demographic questions used in the NHIS did not include gender identity variables. Given that population estimates for TGNC individuals are low, it is unlikely that the presence of TGNC individuals in the NHIS data would

[1] Because of missing data, the total n within each demographic category varies; however, percentages are based on the total within the demographic category.

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have skewed the results (Scout & Gates, 2014). The first author's institutional review board approved this study.

Measures and Procedure

The NTDS was administered online with the addition of paper-and-pencil surveys for hard-to-reach participants. A full description of the survey protocol can be found in the National Center for Transgender Equality report (Grant et al., 2011). For the purposes of this study, we used the data from questions assessing gender identity, age, race/ethnicity, education, annual household income, relationship status, living arrangements, employment status, type of health insurance, and place to access care (e.g., "What place do you go to most often when you are sick or need advice about your health?").

The NHIS is broken down into several parts. At the highest level, data are collected about the household. This includes information about the number of people who live in the house. The next level of data is information about the family. This includes basic health information and demographic data such as employment. The person level includes demographic data, general health information, type of health insurance coverage, and the place where the person seeks medical care (e.g., place usually go to when sick). Data for adults includes specific health information (e.g., most recent blood pressure levels). The exact questions are not available on the CDC web site; however, the NHIS dataset includes summary files with labels for the questions that were asked. Items were matched from the NHIS labels and NTDS dataset to create equivalent comparisons.

Data Analysis

Data were analyzed using SPSS Version 22 (IBM SPSS Statistics, Armonk, NY). To address the discrepancy in sample size between the NHIS and NTDS, we took a random sample of NHIS participants to create a sample comparable to the size of the NTDS study. We used only those participants from the NTDS who provided an answer to the question "what is your primary gender identity today?" We divided the dataset into five random samples and tested for statistically significant differences across variables of interest; none were found. As a result, we proceeded to utilize all of the NHIS participants who provided a response to the gender question.

Descriptive statistics were computed for all variables. The datasets were not combined due to differences in the ways the questions were asked across the two surveys. Therefore, we were unable to conduct *t* tests to determine if there were significant differences across the datasets in the demographic variables. Chi-square tests were computed to determine the following: (a) differences in insurance coverage based on gender (cisgender/NHIS compared to TGNC/NTDS); (b) insurance coverage based on geographic region; (c) the type of care a person had access to based on insurance coverage (data was transformed into nominal groups to allow for comparison); and (d) differences in access to care based on race/ethnicity. We used $p < .05$ to determine statistical significance for chi-square tests.

Results

Gender Differences in Insurance Coverage

A chi-square test was used to determine whether there was a significant difference between cisgender and TGNC individuals in their likelihood of having insurance. There was a statistically significant difference between cisgender and TGNC individuals in health insurance coverage, $\chi^2(1, N = 28{,}052) = 13.13$, $p < .001$, Cramér's V = .02. Cisgender individuals were statistically more likely to have insurance than TGNC individuals (18.8% vs. 16.6%, respectively). Only one statistically significant relationship was found for TGNC subgroups, when each subgroup was compared with cisgender individuals; MTF TGNC individuals were less likely to be insured than cisgender individuals.

Insurance Coverage and Geographic Region

A significant difference was found for insurance coverage between cisgender and TGNC individuals in the Midwest, $\chi^2(1, N = 6{,}190) = 37.97$, $p < .001$, Cramér's V = .08, and the South, $\chi^2(1, N = 9{,}121) = 13.63$, $p < .001$, Cramér's V = .04 (see Table 2). In some locations, TGNC people were less likely to have insurance coverage than cisgender people. In the Midwest, only 13.7% of cisgender individuals were uninsured compared to 20.6% of TGNC individuals. In the South, 19.5% of cisgender individuals were uninsured compared to 24.2% of TGNC individuals. TGNC individuals were insured at lower rates than cisgender individuals in the Midwest and South. No significant differences were found between cisgender and TGNC individuals in the Northeast or West.

Gender Differences in Location of Care

A chi-square test was used to determine whether there was a significant difference between cisgender and TGNC individuals in the place (e.g., doctor's office, emergency room) where they receive health care (74.2% vs. 25.8% respectively). A significant difference was found between the cisgender and transgender individuals, $\chi^2(6, N = 24{,}477) = 2302$, $p < .001$, Cramér's V = .31. In addition, there was a significant difference between TGNC and cisgender individuals receiving health care at the emergency room, $\chi^2(1, N = 24{,}477) = 211.39$, $p < .001$, Cramér's V = .09. Cisgender individuals were less likely than TGNC individuals to

Table 2
Location for Accessing Care for Cisgender and Transgender and Gender Nonconforming (TGNC) Individuals Who Are Insured

Place to access care	TGNC *n* (%)	Cisgender *n* (%)	χ^2	Cramér's V
Emergency room	256 (4.1)	210 (1.1)	211.39	.09
Doctor's office	3,764 (59.7)	13,623 (75.0)	531.34**	.15
Clinic	1,090 (17.3)	3,673 (20.2)	26.62	.03
Hospital/VA	231 (3.6)	313 (1.7)	81.13	.06
Other	150 (2.4)	171 (0.9)	74.76	.06
Don't use healthcare	386 (6.1)	181 (1.0)	543.41	.15

** $p < .001$.

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visit the emergency room (1.2% vs. 4.1%, respectively). There was also a significant difference between TGNC and cisgender individuals receiving health care at the doctor's office, $\chi^2(1, N = 24{,}477) = 531.34$, $p < .001$, Cramér's V = .15. Cisgender individuals were more likely than TGNC individuals to visit the doctor's office (75% vs. 59.7%, respectively). There was a significant difference between TGNC and cisgender individuals receiving health care at the health clinic, $\chi^2(1, N = 24{,}477) = 25.62$, $p < .001$, Cramér's V = .03; 20.2% of cisgender individuals visited the health clinic compared with 17.3% of trans individuals. There was a significant difference between cisgender and TGNC individuals receiving health care at the Department of Veterans Affairs (VA), $\chi^2(1, N = 24{,}477) = 81.13$, $p < .001$, Cramér's V = .06; 1.7% of cisgender individuals visited the VA compared with 3.7% of trans individuals. There was a significant difference between TGNC and cisgender individuals receiving health care at the alternative facilities, $\chi^2(1, N = 24{,}477) = 74.76$, $p < .001$, Cramér's V = .06; 0.9% of cisgender individuals visited alternative medicine compared with 2.4% of trans individuals. There was a significant difference between TGNC and cisgender individuals not receiving health care, $\chi^2(1, N = 24{,}477) = 543.41$, $p < .001$, Cramér's V = .15; 1.0% of cisgender individuals reported not using health care compared with 6% of trans individuals. Refer to Table 2 for specific TGNC and cisgender comparisons on health care access.

Race/Ethnicity Differences in Insurance and Location of Care

A significant relationship was found between racial/ethnic minority and White TGNC individuals regarding insurance coverage, $\chi^2(1, N = 6{,}222) = 51.75$, $p < .001$, Cramér's V = .09. White trans individuals were more likely to report having insurance than racial/ethnic minority trans individuals (82.9% vs. 74.3%, respectively). A significant relationship between the two groups was also found regarding the location where they receive health care, $\chi^2(1, N = 6{,}263) = 149.32.76$, $p < .001$, Cramér's V = .15. When accessing the ER, 7.4% of racial and ethnic minority TGNC people used the ER, compared with 3.1% of White TGNC people. Similar results were found for individuals accessing a clinic; 11.0% of racial and ethnic minority TGNC people used a clinic, compared with 5.65% of White TGNC people. See Table 3 for a breakdown of these results.

Table 3
Racial/Ethnic Minority Transgender and Gender Nonconforming People Compared With White People: Access to Care

Place to access care	REM *n* (%)	White *n* (%)	χ^2	Cramér's V
Emergency room	104 (7.4)	151 (3.1)	50.41**	.09
Doctor's office	687 (48.6)	3,053 (63.0)	94.05**	.12
Clinic	268 (18.9)	813 (16.8)	3.67	.02
Hospital/VA	51 (3.6)	179 (3.7)	0.02	<.00
Other	50 (3.5)	99 (2.0)	10.53*	.04
Don't use healthcare	98 (6.9)	283 (5.8)	2.30	.02

Note. REM = Racial and ethnic minority.
* $p < .01$. ** $p < .001$.

Discussion

The purpose of the current study was to examine TGNC individuals' insurance coverage and access to health care. The results indicated that cisgender individuals reported more health care coverage than TGNC individuals (16.6% of cisgender individuals were uninsured while 18.8% of TGNC individuals were uninsured; effect size = .02). Although these data indicate that the TGNC sample may have higher reported rates of insurance than other studies that focused exclusively on TGNC individuals (e.g., Sanchez, Sanchez, & Danoff, 2009), the results support existing data that significant disparities exist in health care coverage for TGNC individuals compared to cisgender individuals. Previous research related to overall insurance coverage for TGNC individuals did not compare TGNC individuals to cisgender individuals; the results from the current study provide specific information as to the extent of the health disparities for insurance coverage.

Findings from the current study indicate a greater need to assess health insurance coverage across the United States, rather than primarily focusing on cities that may provide better resources (e.g., San Francisco and New York City). Previous research indicated that location can have a substantial impact on LGBT individuals in terms of family relationships, quality of life, homophobia/transphobia, and equal rights (Oswald & Culton, 2003), suggesting a greater need to delve into how insurance, specifically, affects TGNC individuals based on location. Because data reflects differences in rates of insurance across regions of the United States, it appears that there is not an overarching insurance model that fits the needs for the entire TGNC community. As a response to this, several states (e.g., Pennsylvania and Virginia) have begun reporting on the specific health disparities for the TGNC community in order to address regional needs and to ensure that every person's needs are being addressed (Bradford, Reisner, Honnold, & Xavier, 2013; Kenagy, 2005). Research has also indicated that gay men experience more discrimination in Southern and Midwestern states than in Western and Northeastern states (Tilcsik, 2011); research also indicates that transgender individuals report more mental health disparities in the South and Midwest than cisgender individuals (Citation masked for review). As well, even with the implementation of the Affordable Care Act, Southern states continue to have the lowest rates of insured individuals (Kenney et al., 2012) and policies and politics that within the South have a direct impact on specific groups of individuals' access to health care (Adimora, Ramirez, Scheonbach, & Cohen, 2014). Although we acknowledge that gay men and TGNC individuals have different experiences, it may be possible that Southern and Midwestern states do not have infrastructure in place to support TGNC individuals' needs for health insurance. Southern and Midwestern states, specifically, should conduct their own needs assessments.

In addition to reporting lower levels of insurance coverage, TGNC individuals also reported lower levels of access to health care facilities than cisgender individuals. Out of all findings in the current study, this difference indicated the strongest effect (Cramer's V = .31). These findings are consistent with other minority groups' reports of accessing health care (Shaw et al., 2013; Uscher-Pines, Pines, Kellermann, Gillen, & Mehrotra,

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2013). Shaw et al. (2013) reported that the decision-making process to use the ER in nonurgent health care situations is influenced by many factors, with perceived barriers and avoidance of discrimination as two primary factors. It is possible that TGNC individuals within the current study used a similar decision-making process, as most TGNC individuals report that they believe it is difficult to find transgender-competent providers (Sanchez et al., 2009).

Finally, our findings reflect that TGNC racial/ethnic minorities reported lower levels of insurance coverage when compared to TGNC White individuals. In recent years, there has been an effort to focus on disparities within the TGNC community, with racial/ethnic minority identity being a primary factor (see Bith-Melander et al., 2010; Singh, 2013; Xavier et al., 2005). To date, we are unaware of published research that indicates the insurance and access to health care disparities for racial/ethnic minorities within the TGNC community. Recent research has begun to focus on resiliency for TGNC racial/ethnic minorities (Singh, 2013). Though we applaud this research, it is also important to focus on the type and extent of barriers that exist within the health care system to inform interventions to improve resilience and address health disparities.

Limitations

There are several limitations to the current study. First, there are always limitations to secondary data analysis, including a lack of contribution to the wording of questions or capturing psychometrically sound data through validated instruments. Also, it is possible that there were TGNC individuals in the NHIS dataset, even though we classified all participants in this dataset as cisgender. Because of the way the data were collected, it was not possible to determine the sex assigned at birth for the individuals in the NHIS dataset and therefore to determine who was TGNC. Future national surveys should ensure that gender identity is fully captured and accurately assessed. In addition, the results from this study are intended to highlight the disparities in insurance coverage and how TGNC individuals access health care. Because of the nature of the findings, it is difficult to draw conclusions about why these disparities exist, yet, this study is a first step in being able to provide data to conduct future studies on the relationship and implications of these factors. A final limitation is that data used for this study were collected in 2008. Although this represents an important historical picture of the state of health disparities for TGNC individuals, much has changed since the passage of the Affordable Care Act. Further research is needed to explore if these disparities are still a concern.

Implications

It is essential to assess the state of insurance coverage and access to health care for TGNC individuals. The results of this study are indicative of how large these disparities are within the United States. Given the current climate of implementing the Affordable Care Act there is a demand within the United States to ensure that every person has access to health care, regardless of identity (e.g., gender identity) or socioeconomic status. However, the reality continues to exist that many insurance companies do not cover TGNC medical or psychological interventions, and even when they do, specific plans, computer systems, and identification of treatment (e.g., pap smears for FTM individuals) often are not inclusive of TGNC health care. At the time of writing this article, it is recommended to TGNC individuals that they research their own insurance options to determine whether their state covers transition-related care (Human Rights Campaign, 2015). As well, only six states (California, Connecticut, Oregon, Massachusetts, New York, and Washington) have bans on insurance exclusions for transgender health care and provide transgender inclusive health benefits for state employees, two states (Maryland and Minnesota) provide transgender inclusive health benefits for state employees, and three states (Colorado, Illinois, and Vermont) ban insurance exclusions for transgender health care (Human Rights Campaign, 2016).

Our first recommendation is that there is a need for policy change on the federal level to ban insurance exclusions for transgender health care and mandate transgender inclusive health benefits. Findings from our study indicate a large disparity in coverage based on the region where TGNC individuals live. It is reasonable to assume that TGNC individuals would obtain insurance coverage if they knew their insurance coverage would fit their needs. In the meantime while waiting for policy change on the federal level, we recommend that more funding and training be provided to allow for more free TGNC health clinics in the United States. At the time we wrote this article, there were 18 free or sliding scale clinics focusing on TGNC health within the United States (TransHealth, 2016). It is not surprising that only two of these clinics are in the South and Midwest (Trans Health Initiative in Atlanta, Georgia, and Chicago Women's Health Center in Chicago, Illinois). We recommend that more federal funding be appropriated to provide free/sliding-scale fee medical and mental health care for TGNC individuals. Part of this funding should be used to provide community seminars to TGNC individuals to indicate the costs and benefits of visiting an emergency room and when it is necessary to use the ER, as well as providing specific resources within each community of the types of clinics that provide competent and affordable care.

The recent changes in Medicare policy are favorable for TGNC people (National Center for Transgender Equality, 2015). However, the ways in which decisions are made as to who might get coverage, especially for surgeries, has been inconsistent at best. A ruling in early 2016 favored a TGNC woman who had been denied coverage for "genital reconstruction surgery" (Martin, 2016, first paragraph). The development of consistent regulations that allow for access to care that is covered by Medicare is critical for people who rely on this type of insurance coverage. Equally important is the identification of providers who accept Medicare clients and patients. If the rules are changed to be favorable and there are no providers who accept Medicare the community has not gained access to health care.

Along with these funding initiatives and policy changes, we recommend that researchers conduct community participatory action research to discuss in TGNC communities—with a specific focus on the needs of racial/ethnic TGNC minorities—what they need to access health care. At the moment, there are little-to-no data regarding the actual process of how TGNC individuals obtain insurance and the individual barriers that exist. Trainings provided to community members will not be effective unless community members discuss their processes in accessing insurance and health care; thus, longitudinal qualitative and quantitative data should be

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collected to determine the who, what, where, when, and why of insurance processes for TGNC individuals. We recommend that researchers focusing on this topic collaborate with other researchers who have previously conducted community participatory action research to prevent difficulties that have previously occurred and to replicate positive interactions and research procedures (see e.g., Travers et al., 2013).

In this study, we provided information from two national datasets that indicate differences in insurance coverage and health care access based on gender identity, region of the United States, type of health care, and race/ethnicity. It is past overdue for insurance companies to begin providing coverage for TGNC-related health care. If barriers continue to exist (e.g., lack of physician competence and marginal insurance coverage), it will be difficult to create interventions to assist TGNC individuals. A wide, systemic shift must occur to improve health disparities between TGNC and cisgender individuals.

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